LONG ISLAND, A Site in Search of a Use

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Submitted to the Department of Urban Studies and Planning on October 10, 1969 in partial fulfillment of the requirement for the degree of Master of Urban Studies and Planning.

This thesis represents an attempt to investigate and suggest development policies for Long Island, the largest of all the islands in the Boston Harbor. Inordinately well suited to development by virtue of size and connection to the mainland, Long Island possesses a major constraint in the form of a large, functioning hospital for the aged and chronically ill. The likely continued presence of this hospital into the foreseeable future implies certain ways that development should proceed. The thesis proposes one such way that the author considers most desirable.

The thesis is divided into three parts, the first of which is an examination of Long Island as a physical entity. The general implications of an island environment are considered as they have appeared in Western history and literature, followed by a detailed description of Long Island itself. The island presents a number of problems in addition to the hospital, principal among which are water pollution and access restrictions. The limitations imposed by these are severe, but do not preclude the sort of experiment set forth as the most desirable alternative for the island.

The second section of the thesis is an examination of Long Island Chronic Disease Hospital, a facility serving some 900 people with a staff of approximately 400. Begun in the year 1893, the hospital has had a varied and not entirely happy history, which is sketched out at the beginning of this section. Interviews with staff members and patients form the bulk of the section in an attempt to convey something of what the island and the hospital mean to users. No development policy can afford to ignore the future of the hospital, or the major role it is presently playing in the metropolitan area.

The final section examines the various alternatives which have been suggested or are likely for Long Island and presents an experimental solution with a significant chance of becoming a reality. A client, in the form of the South End Guild School, is committed to having its pupils work with patients at Long Island, and possible situations are

suggested where interaction might come about. The hospital itself is quite enthusiastic about such a possibility and the experiment could serve to point up the asset which Boston possesses in the form of Long Island and its people.

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Part I

From the northern tip of Long Island one can see easily to the Brewster Islands and, on a clear day, almost forever, or so it seems. One can also see the Pru and the industrial tumult of South Boston, the smoldering waste of Spectacle Island, the ferry on its way to George's Island and Nantasket. There are many vistas from Long Island, but few see them and few even know the island is there. Yet Long Island, covering 213 acres, is the largest of all the islands in the Boston Lower Harbor. Its precise geographic location is 42°19' north by 70°58' west, but in more ordinary terms it is located approximately two miles, via the Moon Head causeway and the Long Island Bridge, from Squantum peninsula, a portion of the city of Quincy. Taken together, Squantum, the causeway, Moon Head, and Long Island form a long spine of land dividing Dorchester Bay from Quincy Bay in the Boston Harbor. The northern tip of Long Island lies directly south of Deer Island, almost a mile across the President Roads, main shipping channel for the port of Boston.

Geologically, the island is three drumlins connected by littoral deposits, or perhaps by low-lying glacial deposits.[1] Drumlins are a familiar feature of the Boston Harbor area, as well as of the filled

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[1]Clifford Kaye,"Erosion of a Sea Cliff," Economic Geology in Massachusetts. University of Massachusetts, 1962, p. 521.

land that was once part of the Boston Harbor. They are smooth, round hills composed of glacial till, material left behind by the receding glaciers. Subsequent to the retreat of the glaciers, the land around the Boston Harbor sank, and the drumlins became the islands of the harbor. Left on land, and typical of the formation, are Beacon Hill and Bunker Hill. Geologic processes never remaining static, the west head of Long Island is eroding at a fairly constant rate. The action of rainfall and spring thaws is resulting in a retreat of the sea cliff there of 0.34' per year.[2]

In the most basic physical terms, this is Long Island. It is, and has been, much more, because of its use as the site for the Long Island Chronic Disease Hospital, Fort Strong, and the now de-activated Nike missile site. Its potential is significant, partially because of its size and its connection to the mainland, but primarily because of its magnificent amenity value and the fact that it is an island, with all that implies, particularly in proximity to a high density, urban area.

Implications of an Island

"Island" has special implications anywhere. The Vineyard Gazette, newspaper of Martha's Vineyard, puts it explicitly: "Of all the Earth's surfaces, the islands are the aristocrats." Perhaps the phrase says more about the inhabitants of the Vineyard than it does about islands, but the suggestions are clear. Around the world, in history,

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[2] Ibid., p. 521.

in literature, and in everyday perception, islands are special places. Irving Goffman says islands are "null places" where the idea of territoriality is lessened; because islands seem to belong to nobody, they belong to everybody. I would rather say that because islands are removed physically from the mainland, they are removed emotionally as well. The rules for appropriate behavior are relaxed on an island. The unlikely becomes the usual.

Within our culture, the physical setting is a pervasive and immediate index of socially expected behavior. Certain forms of the environment have become charged with social meaning to the extent that an individual's behavior within them is predictable even in the absence of other actors. Islands have been spatially outside the arena of intense human activity. They have been, and still largely are, inaccessible and underdeveloped. Few specific behavior rules have been attached to them, such as, for example, to a church or to a busy city street. Perhaps this is solely because they are hard to reach and consequently little used. Perhaps, on the other hand, it is because they are more clearly part of the sea than part of the land; they don't quite belong to the routine world of human activity; they aren't <u>really</u> "ours." To speculate is interesting, but to deny that islands have any special emotional qualities would be, at the very least, unrealistic.

Throughout Western history, islands have always retained a special role.[3] In ancient Greece, a popular legend (Hesoid, <u>Works and Days</u>) was woven

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[3]David Lowenthal, ed., <u>Environmental Perception and Behavior</u>, University of Chicago, 1967.

around the Island of the Blessed, where the heroes of Greece were provided with three unearned harvests each year. A parallel to this legend appears in Plutarch, who described an island paradise reserved for gods and heroes. This Garden of Eden image spread through medieval Europe with the popular legends of St. Brendan. The saint was a seafaring hero who reputedly had discovered island paradises of unlimited abundance. These fables persisted in Europe throughout the fifteenth century, around which time the image of island seemed to change in the popular media from that of paradise to one of social utopia. Both Thomas More and Francis Bacon contemplated island utopias, as did Shakespeare in The Tempest, (Act II, Scene 1).

Literature of the eighteenth and nineteenth centuries drew on the island image, usually to establish a setting free from the constraints of ordinary society. Perhaps the classic example is Robinson Crusoe, which produced a score of imitations in its description of a man who must be supremely self-reliant because the supports of civilization have been shorn away. Two of Joseph Conrad's most famous works, Victory, and Lord Jim, rely on the island environment to reinforce the emotional isolation of the protagonist.

In our own time, Aldous Huxley has described an imaginary island utopia (Island, Harper and Rowe, 1962) in the South Seas, and even current television trades on the island theme. The characters of Gilligan's Island pour out vast quantities of unlikely and usually strained ingenuity every night on Channel 56. The island is the essence of the

show; nothing on the mainland would induce such cooperation, except perhaps some total institutional environments, a fact which also conveys something of the flavor of "island."

An island is a place for the unusual, a place for adventure, wanted or not. It is a place for escape, a null place, a free fragment on the edge of the world. The names connote romance and the exotic: Nantucket, Fire Island, Santa Catalina, Key Biscayne, Trinidad, Tobego, a "South Sea island paradise." Places for escape, for retreat, for refreshment, for unwinding, for accepting the unexpected, for getting away from it all.

Traditionally, islands have also been the special province of the wealthy, the privileged, or the mavericks of society. They have been the turf of the Aristotle Onassises, the Kennedys, or the Axel Heysts (Victory). They have been out of reach physically and financially of those less fortunate or less adventuresome. And, in the case of Boston, if they were close enough to the shore to be of any value to the ordinary population, they were co-opted for public and generally undesirable uses. The history of the Boston Harbor Islands is a catalog of objectionable social uses: prisons on Deer Island and Gallups Island, a paupers' home on Rainsford Island, a quarantine station on Long Island, a dead animal rendering plant and garbage dump on Spectacle, a target range for heavy ordnance on Peddocks. Hardly activities calling up the same island image as Jamaica or Hawaii.

The Long Island Image

Long Island is no exception to the dreary history of Boston Harbor. Today, as well as being a null place, it is also a place for null people, or at least people who have been perceived as such by the larger population for some time. The image of the island is conferred by the hospital, officially the Long Island Chronic Disease Hospital. This facility has been a quarantine hospital, a paupers' home, a home for unwed mothers, a tuberculosis sanatorium, a major general hospital, and a home for alcoholics during the years since its inception in the latter part of the nineteenth century. Emotionally, it is something far more threatening for many. It is The End. A Quincy drunk put it this way: "When I finally get to Long Island, I know it's all over." His words may not be as forbidding as Dante's over the gate of Hell, but most see it that way. The island is perceived as a site for unwanted uses: a fort in ruins, an abandoned missile site, a dump, a potter's field, and a hospital for the aged poor. It is a place which seems forbidding and isolated. The journey to it takes you past the old Moon Head sewage disposal outlet, built in 1878, and that medieval facility establishes the tone. The emotional setting is one of a place you want to leave, a place you'd rather not visit alone, a place no one knows is there and where entry feels like intrusion. A few visit the island by car, but none by foot. A walk around the sea wall on the northern end of the island feels uncomfortable. The buildings of the fort erode in the weather and disappear behind weeds.

Some of the buildings have been torn down, but for no obvious purpose and the aimless piles of brick remain. The old Nike site is padlocked, the hospital is guarded, and the beaches are polluted. The challenge of Long Island is plain: can all this, including the image, be changed, and be changed without removing the hospital? Hopefully, the answer is yes. But to change the image it will be necessary to introduce new people and new activities. Some of the existing settings will have to be changed. The fort offers great imaginative potential; the missile site and the dump must be removed; the potter's field must be softened. These things are well within the realm of the possible. Other problems will be more difficult to solve, but none should preclude an effort. In any case, an understanding of Long Island, its history, its present uses, its residents, its physical nature, and its disadvantages is necessary before any reasonable proposal can be weighed.

The Island Itself: A Detailed Description

The first recorded inhabitant of Long Island was a gentleman named John Nelson, who lived there during the latter part of the eighteenth century, at which time it was referred to as Nelson's Island. The first lighthouse was placed on the island in 1794, and the existing light at Long Island Head was built in 1819. For almost a century, the light was tended by a regular keeper, but operates automatically today. During the Civil War, Long Island was used as a conscript camp and a portion of an active-duty regiment was quartered there during the con-

flict. Fort Strong, however, was not built until 1867. An active post during the Spanish War, the fort also housed more than 1,000 men during World War I, most of them from a coastal artillery regiment. The fort was re-activated during World War II, but was taken from government service and given to the city of Boston in 1949. From approximately 1850 until 1887, Long Island was home to a colony of Portuguese immigrants. They were finally evicted by the city just prior to the construction of Long Island Hospital, which opened as a paupers' home in 1895. Its residents came from adjacent Rainsford Island, which had served in this capacity for almost fifty years. Until 1951, Long Island's only connection to the mainland was by boat, but the present bridge was opened to traffic on August 4 of that year.

Water Quality

As previously mentioned, Long Island is the largest of the harbor islands, covering 213 acres. Nearly two miles long, it is slightly less than 500 yards across at the widest point. Its shoreline length is $5\frac{1}{4}$ miles, approximately equally divided between the Dorchester Bay and Quincy Bay sides of the islands. (See Appendix A, #3.) Of these two, only the Quincy side is presently acceptable for water contact sports and the pollution level is still rather high. The Dorchester Bay side of the island is heavily polluted, due primarily to the incorrect operation of the MDC disposal plant at Deer Island, but also to the continued use of the antiquated Moon Head facility by the community of Squantum. Continuous proper operation of existing facilities and

elimination of deficient disposal sources would be a necessary first step to the development of water recreation at Long Island.

According to the Federal Water Pollution Control Administration, the waters surrounding Long Island on both sides are rated SB by the Commonwealth of Massachusetts. This designation means that the waters are considered acceptable for bathing and recreation, including all water contact sports. The Massachusetts standards consider coliform bacteria counts in the determination of this rating, with the allowable amount of such bacteria not to exceed 700 per 100 ml of sample taken, and not to exceed 2300 in over 10% of the samples taken in any given monthly period. The federal coliform densities for the waters around Long Island are 27,000/100 ml on the Dorchester Bay side and 17,000/100 ml in a sample taken between Rainsford Island and Long Island.[4] Coliform bacteria is generally harmless in itself, but it is considered a good indicator of the possible presence of pathogenic bacteria. The ingestion of pathogenic bacteria can cause intestinal disease and body contact with water polluted by them can cause various forms of infection. There is thus an apparent difference between the Massachusetts rating and the results of federal sampling. The latter are supported by comments of the Long Island Hospital staff, who consider the Dorchester Bay waters

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[4]Report on Pollution of the Navigable Waters of Boston Harbor, Federal Water Pollution Control Administration, U.S. Department of the Interior, May, 1968.

totally unacceptable for swimming. The hospital itself does not contribute significantly to the pollution of the harbor. It is equipped with its own sewage treatment plant which is subject to bi-weekly testing. Investigations have indicated that the MDC municipal waste discharge at Deer Island is the major source of bacterial pollution in the waters around Long Island. Clearly, no significant improvement in the recreational use of the island, or indeed of the harbor in general, is possible without an end to pollution.

A map is appended to this report showing the various water quality ratings of the harbor, the major municipal sewage discharges, and the average coliform densities. (Appendix A, #4.)

Foundation Conditions

Adequate information on foundation conditions at Long Island is sorely lacking, as it is for other harbor islands. The only geologic material extant, referred to earlier, describes the west head sea cliff as being composed of compact, cohesive, well-graded glacial till. The fraction smaller than 5mm is 60% sand. In 1958, a new chapel was constructed at the hospital, and some limited boring information is available from the engineering study made at that time. (See Appendix A., #5.) Five borings were taken on the site located near the hospital's main administration building. The borings revealed loose loam, sand, gravel, and some brick fill to depths of between four and six feet. From this

level down to about seven feet, material was predominantly sand and gravel with some amounts of clay. Below this, borings indicated compact sand, clay, and boulders. No water was encountered in any of the tests.

Access

A detailed study of foundation conditions is clearly called for if Long Island is to be considered for any intensive development. Water pollution will also obviously be a factor in its use for recreational purposes. Affecting either, however, is the accessibility of the island to private auto users. The route from downtown Boston to the Neponset Circle and thence through Squantum to the island is congested and slow. Squantum residents are vocal as well as determined to resist the movement of large numbers of cars through their community. Purely from a traffic flow standpoint, the chief bottleneck on the trip occurs in Squantum between Bellevue Street and the beginning of the Moon causeway, where surface width is only 21' and the volume of traffic that can be accommodated is rated 570 VPH. If the entire island were made available for regional recreation, peak flows might approach 2500 VPH; even conservative residential use might call for 1000 VPH during periods of heaviest movement.

The Long Island bridge itself, completed in 1951, is sound and in need of only routine maintenance. According to Professor Siegfried Breuning

of M.I.T., studies of structural data indicate the bridge cannot be double-decked, but could be slightly widened or used for rail transit. It is presently rated at a capacity of approximately 1000 VPH, and is operating far below that level. My own count, made on a Sunday afternoon in April with exceedingly warm weather, indicated an approximate flow of 20-30 VPH in each direction.

Weather

There are no precise records available on Long Island's weather, but conversations with the director and staff members have suggested that conditions are certainly not worse than on the mainland, and actually better in some respects. Snow accumulation is less on the island and temperatures are perceived as slightly cooler in the summer and warmer in the winter. The chief objection to island weather is the velocity of the north wind which has, at times, made heating difficult on that side of the island. Annual precipitation for the island, as for the rest of the harbor, averages 43 inches.

Other Characteristics

The enigma of Long Island is the fort on its northernmost tip. The above-ground gun emplacements are essentially all that remains, with the exception of two concrete structures at the base of the hill. It is unclear, however, just how many rooms or magazines exist underground and my attempts to discover this through the Corps of Engineers were unsuccessful. Plans for the fort no longer exist. The fort might thus

have great re-use potential for recreation, or it might be extremely hazardous inside. An exploration of this facility is called for, although it might prove disappointing.

Attached site diagrams provide some feeling for the main topographical features of Long Island. (See Appendix A., #2.) Cover is extremely sparse on the island, with heavy groves of trees occuring only at the southern end. The low lying areas joining the drumlins or high ground are subject to accumulation of ground water and would seem unlikely spots for construction. Unfortunately, these are also the only large level areas on the island, except for the sites occupied by the hospital and cemetery.

Pollution of the beaches has been referred to before, but it is worth noting that the shore on Quincy Bay has natural deposits of sand, whereas that on the Dorchester Bay side is composed entirely of rock. The tidal flats around the island are extensive, particularly at the northern head. Removal of these would be a necessary condition for intensive recreational use, but it is possible that such dredged material could be used elsewhere for fill in harbor development work.

A final note should be made of the cemeteries on Long Island. The largest one, approximately three acres, is a potter's field containing some 2,000 unmarked graves. This cemetery has not been used by the

hospital for many years. The other cemetery is quite small. In it are 79 graves of Union and Confederate dead. A bronze plaque lists the names of these soldiers and the cemetery is considered a site of some national historical interest.

Advantages and Problems

This then, in general descriptive terms, is Long Island. But the island, like any other space, is more than the sum of its physical features. From the standpoint of development or utilization, it is also a collection of opportunities and problems, some of which admit of ready solutions and some of which strongly indicate the direction any development should take. The opportunities of the island can be summarized as follows:

1. Open space close to the central core.
2. Potential beaches and other water amenities.
3. Bridge connection to mainland.
4. Sufficient area to accommodate large numbers of visitors.
5. Climate.
6. Backed up by open land (Squantum Point) for expanded transportation access.
7. Good views over channel, other islands, and to Boston.
8. Fort site. (See Appendix A., #6.)
9. Presumably good foundation conditions on drumlins.
10. Already under public ownership.

Some of these advantages are unclear or ambiguous, particularly the foundation conditions and the fort site. Others will require substantial

investment for their full potential to be realized. This is certainly the case with the beaches, for pollution abatement is both a lengthy and expensive process. It will be argued that proximity to the central core is an advantage only when Long Island is viewed on a map; that, in fact, the journey to the island is a tedious one in point of time. This may well be true for persons coming from the CBD, or from the western or northern suburbs. But Long Island is within reach of those persons who can least afford to travel elsewhere for recreation. For the most part, the harbor is ringed by communities comprised of lower-middle or lower class persons for whom the journey to more distant recreation spots is difficult or impossible. Admittedly, transportation channels to the island will require substantial improvement if large numbers of visitors are to come there, but this is not an insoluble problem.

Some of the problems of Long Island have been generally described before. Water pollution in particular has been referred to in some detail. Other problems of the island are:

1. Air noise.
2. Short season (for recreational use).
3. Hospital and attendant facilities.
4. Image problem caused by hospital.
5. Inadequate transportation channels to island.
6. Service provision difficulties (for urbanization).

Air noise is a problem for most of the harbor islands, and, indeed, for many of the communities surrounding the harbor as well. Long Island falls into Zone II (composite noise rating 90-100) on Professor Robert Simpson's airport noise evaluation study executed for the M.I.T. Boston Harbor Study.[5] This indicates that residential, commercial, and industrial usages are all possible. Unfortunately, the tip of the island, including that portion occupied by the hospital, falls into Zone III, with a CNR of 100-115. Professor Simpson feels this would preclude ordinary residential construction on that part of the island, and might well cause problems for office building usage as well. This part of the island is affected severely by noise when the southeast runway is being used at Logan. This runway is being extended, and it is difficult to predict what its future impact will be. In any case, the probabilities are that it can only be worse than at present. It should be made clear that these predictions for the airport noise situation do not weigh heavily when only recreational use is being considered. Such uses would be relatively unaffected by aircraft noise. Further, discussions with the hospital staff have indicated that noise is not perceived as a serious problem. Under certain conditions, conversation must be stopped, but this is an occurrence no more frequent than in Cambridge and probably less so than in East or South Boston.

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[5] Considerations Arising from Logan Airport, R. W. Simpson, unpublished paper for Boston Harbor Study Project, M.I.T. Department of Aeronautical Engineering, 1968, p. 3.

Less subject to human change is the problem caused by the relatively short season that the harbor would be available for recreational use. This is a drawback, however, that is serious if water-based recreation is the only consideration.

Linear recreation routes, overlook areas, pleasure domes, covered picnic areas, etc., are all activities which would be less affected by the season. Sledding or simple skiing areas might also be developed to permit use of the island during the winter months.

Even at present, under the existing conditions of water pollution and difficulty of access, Georges Island had 67,000 visitors in 1966[6] and it is surely reasonable to anticipate that Long Island could do as well if similar facilities were made available.

The presence of the hospital constitutes an image problem for Long Island, as well as a serious development constraint because of its location on the best piece of island terrain. Perhaps the image is the most difficult issue with which to cope. Few people understand the true nature of the hospital, fewer still are willing to be in any sort of contact with its patients. This is, of course, the original reason for locating such a facility in the harbor; like the garbage dumped on Spectacle Island, the intent was to remove this objectionable residue

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[6] Open Space and Recreation Program for Metropolitan Boston, Vol. 2, Boston Harbor Metropolitan Area Planning Council, 1967, p. 17.

of society from public view. Precisely how this image problem can be eliminated is unclear. Skillful public relations efforts are certainly called for. The introduction of different user groups would also be helpful. Ultimately, the hospital may be removed.

Plans for this are already under consideration, but are several years behind in implementation. But this change should come about only after new uses of the island have been established and adequate open space for the hospital is provided elsewhere. It is reasonable to assume that no matter what else is done to the island, many visitors will still be imhibited by the presence of the hospital, and the island is too beautiful, too unique, and too large to be thus foreclosed to those who might otherwise benefit from it.

Assumptions and Constraints

The various advantages and problems of Long Island lead to a set of assumptions and constraints concerning the use of the space. These have been examined or at least suggested before, but it would be helpful to summarize them as follows:

Assumptions

1. No significant reduction in Dorchester Bay water pollution will occur for ten years.
2. Air noise will continue to be a problem for residential development with no foreseeable reduction over present levels.
3. Access to the island via private auto will continue difficult for the next ten to fifteen years.

4. Public transit access to the island will not improve beyond present levels as long as the hospital exists or the island is devoted to low intensity, seasonal uses.

5. The hospital, in its present configuration, will continue for a minimum of ten years.

6. The Commonwealth will make no substantial investment in island development until the hospital is phased out.

7. Private investors will not be attracted to the island while the hospital exists.

8. The federal government will probably control the island within ten years. [7]

Constraints

1. Activities should not be oriented exclusively to water-based recreation.

2. Activities should not depend on bringing large numbers of visitors to the island via private auto.

3. Development should be insensitive to air noise.

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[7]Edward M. Kennedy, "A Treasury of Islands," Boston Magazine, May 1969, p. 50.

Part II

Long Island Hospital

It is obvious that, at the present moment, the most serious constraint to the full utilization of Long Island is its hospital. The size, function, history, and likely future of this facility are not well known. Even less well known are the feelings and opinions of those who work there, or who must live there as patients. The unfortunate tendency in harbor planning seems to be to ignore the hospital, despite the fact that it is presently serving a vital social need, and one that cannot readily be accommodated elsewhere in the city without the expenditure of a quite large sum of money. It is even questionable that another site in the city could serve the hospital as well. Opinions of the residents about the nature of their island location should certainly be considered when selecting another site. This portion of the thesis will attempt, through interviews and personal observation, to convey something of the quality of Long Island Hospital. The facts relating to this facility are presented as well, for they will shed some light on the magnitude of the task involved in relocating the hospital.

Following is a brief outline history of the hospital. The material has been gleaned from various records of the hospital and from conversations with Miss Ann Hickey, the head nurse, who has worked on the island, and lived there much of the time, for 48 years.

1873 - The original building on the island was the Eutaw House hotel, an upper income resort facility featuring, among other attractions, prize fights, which were apparently not tolerated in the city at that time. Part of the present administration building was a portion of that hotel.

1882 - The City of Boston purchased the island, except for 50 acres owned by the federal government.

1885 - A home for paupers was constructed on the island. 650 inmates were quartered there.

1891 - The present hospital was started, utilizing some of the facilities of the hotel and the paupers' home.

1893 - Hospital completed and a nurses training school was opened.

1896 - The hospital became officially the Boston Almshouse, with patients referred from the city Institutions Office.

1921 - Hospital became home for unwed mothers. From this date until 1965, the hospital also served as a general facility, with major surgery capability and a capacity of 1500 beds.

1928 - A dormitory for homeless men was opened on the island.

1932 - The first recreation hall for patients was opened.

1940 - The present dormitory for alcoholics was opened.

1949 - The federal government relinquished site of Fort Strong.

1951 - The present bridge was completed, ending dependence on ferry access to the island. Two of the three piers still stand, one for the hospital and the other for Fort Strong. A third pier on the southeast shore was for coaling and has been destroyed.

Long Island Hospital is presently classified as a long term, extended care facility. Its patients, with very few exceptions, are referred from the Boston City Hospital and it is considered an adjunct of that hospital, working under its jurisdiction. Surgery is no longer performed at Long Island; there is no emergency room and no provision for outpatient care. If patients require intensive medical treatment, they are not referred to Long Island. Alcoholics, however, may voluntarily engage in the hospital's rehabilitation program, after an initial referral from BCH.

Long Island presently has a capacity of 913 beds. Of these, 468 are considered part of the hospital; 333 are for alcoholics, and another 112 are in the dormitory. These latter are essentially for permanent, indigent residents who have no medical problems. The alcoholic ward has an occupancy rate of roughly 66%. The rest of the hospital has a rate consistently exceeding 95%. The average waiting time for admission is two to three weeks for men, slightly longer for women. The average

length of stay for alcoholics is four months. For other patients, the stay depends on the nature of their illness and their family circumstances. The average age of all patients is 54. For alcoholics, the average age is 28.

To serve these patients, the hospital has a staff of 387 persons. Forty-eight of these are residents of the island. There is no resident physician, but a doctor is at the hospital on call at all times. The annual hospital payroll is approximately $2 million.

These are the facts of Long Island Hospital, but they are inadequate to convey the flavor of the place. Certainly they do nothing to indicate how the residents feel about the island or what other uses of the space they would prefer. To get at the answers to these questions, a series of interviews was conducted with patients and staff members.

Interviews

The interview questions used were designed to probe attitudes of the staff concerning three general areas: the advantages of the island, its disadvantages, and their preferences regarding its future. An additional question asked staff members was how they came to work at Long Island in the first place.

No attempt was made to separate staff members according to their position at the hospital. I felt that there would be only small differences across occupational lines. More clear-cut divisions of

opinion occured with the length of time the person had been employed at the hospital. Those staff members who had been there less than approximately two years saw no compelling reason for the hospital to remain on the island. Those who had been there longer, with one exception, felt that the services of the hospital would be seriously impaired if it were to move to the mainland. The exception was Mr. Joseph Scally, social service director, who, like others, placed great value on the open space available to the patients, but believed an island location per se was not critical.

There was no discernable difference of opinion between staff members who lived on the island and those who did not. Once again, the critical variable appeared to be length of time employed at the hospital.

Seven staff members were interviewed. This is admittedly a very small sample when the total number of employees is considered. The intent, however, was not to conduct a definitive survey, but simply to learn something of staff attitude towards the island and the hospital. In most significant respects, staff members were in agreement about the island's main qualities and preferred future.

The questions asked of staff members were as follows:

1. What do you like best about Long Island?
2. What are the problems of living on an island?
3. If the Commonwealth or the federal government were to develop Long Island, what would you like to see happen?

4. What kind of development do you think the residents would prefer?
5. Would the residents (patients) want to meet or talk with visitors to the island?
6. Why did you come to work at Long Island?
7. Do you think the hospital should move?

The most frequent responses to the first question were the phrases "open space," "clean air," "views," and "freedom to move around." No one failed to enumerate these advantages and, without exception, they were perceived as the main reason why the hospital should remain on the island. All respondents felt that the patients valued the open space; all considered it a highly therapeutic quality of the island environment. A substantial number of the residents are ambulatory and the freedom to wander is seen as very important to them. As one respondent put it, "It makes the place seem like less of a jail." Even those respondents who did not consider the island indispensable to the hospital felt that open space and the ability to go out into it were critical.

Less unanimous was the opinion that the island environment conferred a sense of community on the hospital. Opinion on this was divided equally between staff members with long service and those with less than two years on the island. The older ones, however, felt that the sense of community had been quite strong in the days when the island was served

only by boat and that it had diminished greatly since construction of the bridge. One detected a certain wistfulness in their comments on "how it used to be," although all felt the bridge was a great asset.

Perhaps the answers to this question could have been predicted beforehand. Open space is certainly the most obvious asset of the island. More significant was the unanimous conviction that open space was important to the well being of the patients. Any planning for the hospital, and any planning for the island that requires removal of the hospital, should take this into serious consideration.

The second question produced answers nearly as unanimous as the first. All respondents agreed that communication with the mainland, in various forms, was the greatest problem associated with the island. For the majority of respondents, communication meant access; in the winter this becomes an especially difficult problem, although the island generally receives less snow than mainland areas. Difficulty of access was seen by two respondents as creating recruitment problems in that potential employees were unwilling to make the commute from the mainland to Long Island.

It was generally agreed that communication difficulties posed no insurmountable problem to the hospital for it is basically self-sufficient. Adequate stores of food and medical supplies are always on hand; internal power is available through the hospital's own generating equipment. Telephone communication with the mainland is sometimes disrupted, but

in that case the hospital is served by its own two-way radio. Fire fighting apparatus is also stationed at the hospital for emergencies. It was acknowledged that the island location thus created nothing more serious than inconveniences, except in the case of personnel recruitment difficulties.

Question number three asked, "If the Commonwealth were to develop Long Island, what would you like to see happen?" The responses, without exception, indicated a preference for recreation. It might be argued that this is the most obvious answer and that other possibilities are simply not generally known. In reality, the staff seemed thoroughly acquainted with the various schemes that have appeared for harbor development and I was personally careful to explain the basic options that have been proposed. The general feeling, articulated clearly by one doctor, was that the island should be made available to the largest number of users, particularly those who live around the harbor and can least afford to go elsewhere for recreation. The respondents did not feel that the island should be foreclosed through residential development, but should remain open to regional users.

Preference for recreation was qualified by four respondents. Of these, three felt that the alcoholic ward should be moved to the mainland before the island was opened to general visitors. The chief advantage of the island to alcoholic rehabilitation is its isolation; visitors would or might destroy this and might become sources of alcoholic

beverages for the patients. To prevent this, the alcoholics should move or be more tightly controlled if Long Island were turned over to regional recreation.

One staff member felt that recreation on the island should be restricted so that the island would not become another Revere Beach. In general, she felt that beaches should be improved and low intensity facilities (picnic benches, etc.) should be added, but that commercial attractions should not be permitted.

Responses on question 4 concerning the patients' preferences for island use generally followed those of question 3. Low intensity recreation was seen as the development residents would most prefer although, as one respondent put it, "A good many of them could care less what happens to the island." But that same individual also urged that some way be found to bring children to the island. She was not alone in this opinion. Two others in the formal interview series and several persons in casual conversation remarked spontaneously about the desirability of bringing children into some interaction, however slight, with the patients. The respondent quoted above said, "Children are the best thing that could happen to this place. Some of these people haven't seen a child's face for literally years." No one offered any suggestions as to how children might interact with the patients; the feeling seemed to be that just watching children would be enough. Certainly, interaction of any kind

with anyone is more than the patients have now and would be a substantial improvement.

There were some variations in the answers to this question about patient reaction to visitors. One respondent felt that residents would resent the intrusion of younger visitors. Another felt that visitors and patients should be segregated in some manner, with portions of the beach reserved just for the latter. Both these persons were concerned about the possible contacts between the alcoholic patients and the visitors. This was obviously a matter of some seriousness to staff members. If a portion of the island is used for regional recreation and the hospital remains, even if only for a short time, the alcoholic section clearly should be removed to a mainland location or additional security precautions should be taken.

Opinion on question 5, "Would residents want to meet or talk with visitors to the island?" seemed roughly divided on the basis of tenure at the hospital. Those who had been there the longest were the most skeptical about the number of patients who would welcome visitors. There was also some observable tendency for opinion to divide along occupational lines. That is, those respondents who were in the most intimate contact with the patients (doctors, nurses, etc.) were the most pessimistic about the chances of creating any significant interaction. Others were less so, notably the occupational therapist, Mrs. Muriel Burgin,

who felt that the patients would respond to any outside contact or attention at all.

In essence, the responses to question 5 were unanimous in asserting that some patients would want to interact with visitors to the island. The best estimate of the size of this "some" came from the director of the hospital, Mr. Donald Goldberg, who felt that perhaps a maximum of 200 patients would be inclined to meet visitors. This estimate was confirmed by the social service director's guess of 25%. The staff members were somewhat vague about the form any social interaction might take. Conversations with patients themselves were more conclusive on this point.

Should the hospital move to the mainland? Two respondents thought yes, two said not necessarily, and three thought no. In addition, and not part of my formal sampling, the former director of the hospital, now director of BCH, thought no also. The negative responses were basically conditioned by the belief that open space was vital to the welfare of the patients and would not be provided were the hospital to move elsewhere in the city. Of the four who opposed moving the hospital, only one was adamant in her belief that the island itself was crucial. This opinion was freighted with many feelings about the special qualities of the island; the respondent was a resident staff member who has lived on the island for 13 years.

The value of open space was also stressed by those respondents who felt the hospital should move or who were ambiguous about the question. They said, in essence, the hospital could be anywhere provided it had exterior space for the patients to move around in. Many of the patients (approximately 300-400) are ambulatory and are not confined for medical reasons. About 75% of these are alcoholics, but the rest are simply the urban poor and homeless. Exterior space is more than therapy for them, its use is about the only thing they have to do, their only way to mitigate the routine of confinement. Staff feeling, and mine as well, was that society owed them at least that much.

Other reasons were cited for moving the hospital: physical condition of the plant, inconvenient spatial arrangement, difficulty of service from the mainland, recruitment problems (referred to before), and isolation. Those who felt the hospital should remain minimized the importance of these factors.

Patient Interviews

The original intent in this interview series was to ask essentially the same questions of patients as of staff in order to assess attitudes towards the island. This procedure did not hold up. The patients seem a fragile group very much more concerned with their immediate problems in the hospital than with the island as a physical entity. The tobacco

allowance is more important to them than the view; free food is more meaningful than fresh air.

Seven patients were formally interviewed. Numerous others were engaged in casual conversation. Lengths of respondent residence on the island ranged from three weeks to several years. Ages ranged from mid-forties to sixty. Only two were regularly engaged in the occupational therapy program, but one of the others was an artist with a considerable degree of skill in freehand drawing. The patients were generally reluctant to discuss their reason for being at the hospital, although all but two said they were dorm residents, which means alcoholics.

In general, the interviews focused on the following questions:

1. What do you like best about Long Island?
2. What are the problems of living here?
3. If the state were to develop Long Island, what would you like to see happen?
4. Would you want to meet or work with other users of the island, particularly teenagers?
5. Do you think the hospital should move?

The first question seemed to draw out the longest and the most consistent response. Many at first construed it to ask what they liked about the hospital, and these advantages were perceived in the simplest physical terms. They liked the food, and the fact that it was free. They liked

the ability to take a shower, to keep clean, to have clean sheets on their beds once a week. They appreciated the opportunity to do small jobs and thus earn a little money for "smokes." The two on the O.T. program could not speak highly enough of it and expressed surprise that more patients did not volunteer for the craft occupations.

Their perceptions of the island itself were less clear, although one of the men working in the O.T. department told me he got interested in painting through looking at the wildflowers growing near the fort. He described his walks to the fort and his efforts to bring the flowers back so that he might faithfully reproduce their colors. He was unsuccessful in preserving them, but this seemed to be his most important experience of the island as a physical resource.

Others spoke of the island in similar ways. A frequent comment was, "The fresh air here is the best thing for a man." Several mentioned they enjoyed walking and the chance to be outside, especially in the spring and summer. One thought the salt air and the sunshine did him more good than any of the medicines provided by the hospital.

But even if they could not easily articulate their feelings about the island, it was clear that they used the open space surrounding the hospital. With only two exceptions, everyone with whom I spoke was either outside or made frequent mention of being able to go outside. It was

the only spatial quality of the hospital that received any mention at all.

As in the case of the first question, the problems of Long Island were those associated with the hospital rather than the island. There were comments about tobacco being too hard to get (a reward mechanism for the staff?), about pay being too low for working patients, etc. When pressed, no one thought the island itself presented any drawbacks, especially since the construction of the bridge. No one expressed any feelings of isolation and one respondent who had been on the island on three separate occasions regarded it as a welcome respite from living in the South End.

Responses were more articulate to question 3, "If the state were to develop Long Island, what would you like to see happen?" All agreed that the island was too large and too beautiful to be reserved solely for the use of the hospital. Patients strongly felt that others should share the space, although without removal of the hospital. Recreation was the preferred choice, but probably because no other alternative seemed to them reasonable for an island with much open space and a generous shoreline. One man felt the best thing would be to develop a Miami-style gambling casino and resort on the island, a place, as he said, "where a guy could really make some big money." Others were less imaginative, describing swimming and picnic facilities, with some provision for beaches and fishing piers to be used exclusively by the patients themselves.

All saw recreation as a way to bring outsiders to the island so they might have a chance to talk with new people or sell some of the things they make. Such contact would seem possible in a limited way, and might well serve to eliminate some of the frustration felt by those in the O.T. program who have no outlet for their efforts. One patient felt that recreation opportunities would also serve to attract patient families too, and make visitations more frequent and more pleasant. The intent behind the recreation suggestions was fairly clear: bring more people to the island so that it won't be so lonely. And of the people who might come, none would be more welcome than children, especially if there would be an opportunity to work with them.

Those in the O.T. program expressed great willingness to pass on their skills to young people who wanted to learn. Simply meeting people and talking with them was viewed with some hesitancy, but teaching a craft or a skill was, without exception, received enthusiastically. Some involvement which maintained the patient's sense of dignity was clearly important, perhaps especially so to these men who are familiar with almost unending failure and frustration. They feel that they have something to teach, if only there were someone to learn. One elderly man, making pottery, said, "Everyone should have the chance to learn this. I'd be very willing to teach children."

Should the hospital remain on Long Island? Everyone interviewed said yes, although the majority wanted to see other uses made of the island

too. It is perhaps difficult for patients to give another answer to this question because the island is all they know, and in many cases it is a genuine refuge. But it is clearly a non-threatening environment, and with the addition of other people it might well become an even more satisfactory home for these persons who have no other.

Part III

The Alternatives

The purpose of this thesis is twofold. The first intent is to provide an in-depth look at Long Island, its hospital, its people, its advantages and disadvantages. The foregoing has been an attempt to do this. The second purpose of the thesis is to suggest a developmental proposal for Long Island consistent with its nature as a site. To adequately treat this latter, it is necessary to consider the possible alternative uses of the island, if only to point out their limitations.

A New Community

On the surface, perhaps the most attractive use of the island would seem to be for new community development. Such a utilization would address itself to many of Boston's most pressing problems, including housing and the need for an expanded tax base. The recently presented M.I.T. Boston Harbor Study report[8] has argued strongly for such development on a harbor-wide scale. Long Island is a key spatial element in the M.I.T. plan. It is important to examine, however, what the implications of such use might be; the implications not only of the M.I.T. proposal, but of any effort to make the harbor islands into a site for large-scale community development.

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[8] The Harbor Islands, Report of the M.I.T. Study Group to the Massachusetts Harbor Islands Commission, April 1969.

Because of uncertain foundation conditions and the need to protect construction from the dangers of flooding, only about 100 of Long Island's 213 acres might be immediately usable for intensive development. This is the land presently occupied by the hospital and the abandoned Nike missile site, plus a portion of the land between the hospital and the fort. Of this total, the hospital itself covers roughly 40 acres so that full utilization of the site would require removal of that facility.

In terms of a community on Long Island, the M.I.T. proposal[9] calls for an average density of 23 dwelling units per acre. The simple arithmetic (4 persons/dwelling unit) shows that for 100 acres, this would mean a population on Long Island of approximately 9200 persons. Engineering studies of foundation conditions on the island (now seriously inadequate) may reveal that additional land is suitable for intensive use, thus implying a higher eventual population. Were the island to be used exclusively for much higher density development, it is possible to project a population approaching 16,000, even if only the most suitable 100 acres were to be used. Numbers such as this, however, imply problems of access if the only available mode was private auto.

But populations of 9,200 or even 16,000 do not make a significant impact on Boston's pressing problems of housing, tax base, unemployment, etc.[10]

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[9] Ibid., p. 53.

[10] Ibid., p. 32.

As a community development project, Long Island could not stand alone. It would have to be part of a larger effort taking all the major islands of Dorchester Bay, and perhaps involving significant land fill as well. More importantly, it is my belief that residential or commercial projects are the wrong use of the harbor space, and especially the wrong use of Long Island. The reasons for this belief are, to me, compelling.

First and foremost, the beachfront of the Boston Harbor is, as Senator Edward Kennedy has pointed out,[11] a vanishing resource. Commercial developments have co-opted much of the waterfront, and what is left has been given over to private uses or to the provision of transportation channels. Of course Boston has a housing problem, and a tax base problem, and many others as well. But the harbor should be preserved for the enrichment of all the citizens, not simply those who would want to live near its waters or profit from the construction of such residential facilities. Open space provision in the city is already inadequate; open space such as that offered by the harbor islands is non-existent elsewhere. The argument here is for something other than the most economically attractive utilization of Long Island. The time is at hand when economics cannot be the over-riding criteria for determining the future of a resource as valuable as the harbor islands.

There are other pressing reasons for not urbanizing the open space of the harbor. Aircraft noise is certainly one such reason and has been

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[11]Kennedy, op. cit., p. 50.

referred to before. Suitable construction techniques would minimize the effect of noise, but this means extra costs and does nothing about the impact on exterior space users. The island resident who uses exterior space cannot be considered in the same category as the occasional recreation seeker. The resident is subjected to noise on a continuing basis and may be expected to be less tolerant of it than the person who only visits the island on infrequent occasions.

Costs of construction and service provision costs can be predicted to run higher than for similar facilities on the mainland. If landfill becomes necessary for new community development, then costs may rise beyond reasonable limits. If only Long Island were considered as a site for a new community, then the unit costs of services might Well be prohibitive. Difficulty of access to schools, hospitals, police and fire protection, etc., compounds the service provision problem if the community is initially too small to provide its own.

A less tangible drawback to urbanization of Long Island is its visual isolation from the mainland. This is one of the problems at which causeway development was aimed in the M.I.T. Harbor Islands study. Although the skyline of Boston is visible from the island, there is a very pronounced feeling of being a long way off, especially in conditions of fog and rain. This is a situation which might be appreciated by recreation seekers who are trying to "get away from it all," but it does not seem entirely consistent with an attractive new community.

Finally, urbanization of Long Island would be compounding the mistakes of the past by foreclosing the use of the island for any other purpose far into the future. It is true that housing is a pressing need in the metropolitan area at the present moment. But will that always remain the most urgent need? If the islands are taken for that purpose, they will not be readily available again for anything else without substantial investment. Such a situation already exists along much of Boston's waterfront where long-standing commercial development is now viewed as less desirable than the possibility of opening that area to general use and enjoyment by the citizenry. Open space is not only an amenity demanded by a society with more money and leisure time than ever before; open space can serve important psychological needs through providing stimulus release, interaction occasions, etc.[12] Boston is unbelievably fortunate to have an open space resource such as the harbor so close to the core and so little used. Any development should capitalize not on the financial opportunity this offers, but on the human opportunity to make this resource available to the people of the metropolitan area, now and in the future as well.

Conservation

But what then about conservation? It has been argued that the harbor islands should be merely cleaned up and preserved in their natural

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[12]Kevin Lynch, The Openness of Open Space, unpublished paper, 1963.

state. Such a solution would also prohibit the construction of new facilities on the islands, and would limit access to present modes. The harbor would thus remain essentially as it is now, available only to those who own or have access to a boat. This proposal is the mirror image of the intensive development, new community scheme and, as such, suffers from the same critical weakness: it would restrict enjoyment of the harbor to a few persons when the resource should be made available to as large a segment of the population as possible. I feel strongly that concern for the harbor and Long Island as a regional opportunity must preclude such a conservation-oriented approach.

Recreation

The MAPC plan[13] for the development of recreation facilities in the Boston Harbor offers another alternative for Long Island, one more consistent with the opportunities the island offers. The plan would develop the island as "a major center for recreation." The Dorchester Bay side would have a boardwalk, swimming facilities (the plan assumes pollution abatement), provision for court and field games, restaurants, docks, etc. The Quincy Bay shore would be used for family camping areas, and the MAPC envisions 150 to 200 campsites, which might require some fifty acres of ground at a figure of four to seven sites per acre. In sum, the MAPC plan is a reasonable and satisfactory solution for Long Island, which is flawed only by its recommendation that the hospital be

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[13]Boston Harbor Metropolitan Area Planning Council, op. cit., p. 36.

removed as a condition for development. The hospital is, in fact, not the major source of pollution on the Dorchester Bay side of the island as the MAPC states, and utilization of that shore does not depend on its removal.

It is not necessary to wait for elimination of the hospital before anything can happen on Long Island, and such a condition may well push public enjoyment of the space a long way into the future. Relocation of the hospital is some distance off, and the island can be used while the hospital is there; in fact, certain advantages may accrue to a combination of other activities with the hospital. The final stages of this thesis will be an attempt to examine what such activities might be and how they might develop.

The Recreation/Education Alternative

In the foregoing material, the urbanization and conservation alternatives for Long Island have essentially been ruled out primarily on the grounds that they would limit availability of the island. The obvious conclusion, therefore, is that Long Island must be devoted to recreational uses. This is a conclusion shared also by the majority of staff members and patients interviewed at the hospital. But recreation of what sort, and for whom? Obviously, it would not be in the interests of the hospital to convert the island into another Revere, even assuming this could be done. Development like this would also not be the best utilization of the site, which has imaginative potential of a very high order.

It would be initially desirable to introduce persons to Long Island who might have some ability and desire to interact with the patients at the hospital, at least in a limited way. It would also be desirable to control the numbers of such island users in the early stages of development, so that their presence would not constitute a threat to the hospital. Finally, it would be useful to begin experiments at Long Island in order to test the potential of the site, the problems caused by hospital patients, and to serve as a mechanism for calling attention to the opportunities offered by the harbor islands generally.

Development must begin slowly and must involve a carefully selected user group. In the initial stages it must be capable of integrating with the hospital. Conversations with hospital staff members have suggested that children (especially young teenagers) interact successfully and easily with the patients. These impressions have been supported also by Mr. Mayer Spivak of Harvard's Laboratory for Community Psychiatry, and from observation of the reception accorded a group of high school students who gave a singing concert at the hospital. This latter was conceived spontaneously by the teenagers themselves after a visit to the hospital, and they have expressed a desire to continue this effort regularly. In any case, an experiment involving teenagers would indicate if they could fit successfully with the hospital and utilize the island in a way which would be beneficial to other potential user groups.

The island would thus, in the early stages, be used for recreation and education experiments. In the case of Long Island, an unused, open space environment, the two are best combined. The island has physical opportunities...the shore, the fort, the empty buildings and the empty space. It has social opportunities...people who have been removed from sight, who need help and contact, who need the interest of an outside group. It can offer children, such as those from the Boston public school system, a chance to do those things they don't usually get to do:

build something
tear something apart
move around freely
see different things
learn from something other than print
relate to other social groups
be self-directed
express themselves.

An island is the best place to begin such learning. It is away from the emotional as well as the physical constraints of the mainland. It is a special place, with the promise of adventure and escape. In the case of Long Island, it is, most importantly, a place where the old need the young. It is also a place where opportunities exist for:

a different stimulus
doing something not possible in the normal setting
a change of environment

a change of activity

contact with different persons

contact with the environment.

Long Island offers what those who live closest to the harbor most frequently lack, whether children or older people: vistas, open spaces, low stimulus environments, new associations, unexpected situations, contacts with something other than the built environment. Open spaces like this, in and near the city, are valuable, as well as vulnerable. Long Island provides such open space in very significant doses. My proposal for the island is that it should become an education island, at least on an initial, three year experimental basis. It seems the best merger of opportunities and needs at the present time. The remainder of this thesis is an attempt to examine the process such a development might follow, the client group it might serve, the activities involved, and the means by which the success or failure of the effort might be evaluated.

Long Island Experiment

The reasons for the selection of Long Island as a site for educational experiments have been suggested in the foregoing. They can be stated succinctly as follows:

1. Long Island is already publicly owned space;
2. It is connected to the mainland;
3. It has diverse advantages for education, especially for the study of life sciences *in situ* and the opportunity for significant social interaction;

4. It offers substantial recreation potential in the form of beaches, the fort site, and large open space acreage.

Given the above characteristics, it was not difficult to interest a potential client in the island, particularly a client anxious to involve children in experiences outside the normal, static classroom environment. Such a client is the South End Guild School.

A private school not yet funded for operation, the Guild School possesses a highly qualified core faculty, a building in the South End, and a deep concern for education which involves students in a learning process rather than one which simply presents them with collected facts and rules. Concern for this involvement can be seen in its selection of a physical site. The school presently occupies a portion of the A.C.T. Workshop in the South End, a facility organized by Boston's Institute of Contemporary Art for use by the various artists' workshops in the city. Studios for many activities are available, as will be a woodworking shop, and Guild School pupils will have the opportunity of watching and working with other occupants of the building. It is this sort of pupil involvement that the school seeks.

These pupils will be seventh and eighth graders, primarily because other innovative community schools in the area stop at the sixth grade. A gap thus presently exists between primary school and high school for

those parents concerned with offering their children something other than the Boston public school system. It is this gap that the Guild School proposes to fill.

At first, the number of pupils in the school will be small. A group of 50 is presently considered the maximum the school could handle and still retain a satisfactory pupil-teacher ratio. The children will be drawn from the South End, ironically enough, the source of many of the residents of Long Island Hospital.

The Rationale

It could be reasonably asked, "Why should this school have the initial access to Long Island?" There are compelling reasons, and reasons other than "first come, first served." First and foremost, the Guild School is not only willing to work with the hospital but considers this involvement the chief reason for their presence on the island. They see the patients as persons who need interaction with others from the outside and the pupils as persons who need the recognition such interaction could bring about. The school staff feels the children's most urgent need is an increased sense of self-worth and that the best way to instill this is to provide an opportunity for them to be of service to someone else. Thus, the Guild School does considerably more than accept the hospital as a temporary inconvenience on the island; they see it as an integral part of their teaching effort.

Two other factors prompt belief that the Guild School will be able to work satisfactorily with the hospital. One is the age of the pupils.

They will be young teenagers (12-14) and should work easily with hospital patients. Of course, this theory needs to be tested and will in fact be so if the Guild School-Long Island experiment gets underway. Additionally, the pupils will be from the South End, a racially heterogeneous area where they will have seen persons like those encountered at Long Island Hospital so that unfamiliarity will not be a threat.

Given then a rationale for the Guild School's use of Long Island, is there anything in it for the hospital? Do they see such an effort as in their interests and, if so, why and how? Discussions with the hospital director, Mr. Donald Goldberg, and the social service director, Mr. Joseph Scally, have indicated that the introduction of young people to the island would be a highly therapeutic experience for the patients. The occupational therapist, Mrs. Muriel Burgin, has suggested the way such involvement might take place.

The occupational therapy section at Long Island Hospital is hampered by insufficient staff. Approximately fifty patients are involved in the program, and there are only two full-time staff members. On the other hand, the O.T. facility is well equipped with a wide variety of tools and materials. Additional supplies are relatively easy to obtain. Many of the patients on the O.T. program have considerable skill, but suffer from a sense of frustration in that their efforts and their talents have no tangible outlet. The staff feels that pupils would be of constructive

help to patients on the program, would give them a feeling that their work was important, and provide them with the satisfaction of perhaps teaching someone else. Again, this effort would be experimental, but the hospital feels it would have a very high probability of success.

As mentioned before, the Guild School is vitally concerned with the hospital, seeing opportunities for the students to gain both self-respect and skills through interaction with the patients. The island, of course, offers in addition a physical environment the school perceives as important to its educational goals. As a site for the study of the life sciences, it is difficult to equal in the metropolitan area. Over twenty-three varieties of wildflowers have been identified on its northern end. Its location makes it ideal for the study of ecology; its composition makes it an excellent point of departure for an examination of the geological history of this area. In addition, the fort itself offers a wide range of educational opportunities. The old gun emplacements make, or could make, ideal natural amphitheaters for classes. There are many interior rooms and passageways for exploration or use during inclement weather. Most of these rooms are furnished with electrical outlets; it is possible that much of the wiring is intact or could be replaced for a nominal cost. An intriguing headquarters building still stands; it has an exterior structure of reinforced concrete but within that, standing free, is a complete wood frame house with wood floors and clapboard siding. Rehabilitation of this would be a worthwhile exercise in carpentry, and there are hospital

patients with skills in this area who might also be involved. The old pier which once served the fort is also wood and though its reconstruction would require a major effort, it is possible that some of the teenagers could be involved. The pier might later be used to ferry pupils or visitors to the island during good weather.

There is an abundance of building material everywhere on the fort site. The brick buildings have been torn down, but the bricks were not removed. Many fine timbers are scattered about, including a large number of 2 x 8 boards all of which could be used for construction projects. In short, the fort offers the school opportunities of a similar nature as the hospital: chances for involvement, for experimentation, for interaction, for learning by doing.

The Process

The sequence such activity might follow is not difficult to imagine. Both hospital and school personnel feel it might be premature to involve pupils with patients on any sort of large scale as soon as the experiment begins. Therefore, the initial group of students working with patients would be no more than ten and would be selected on a volunteer basis. These pupils would begin by working in the occupational therapy section of the hospital and might indeed continue for their two years if such was their interest. The remaining pupils would begin re-hab and exploration of the fort. All pupils would meet together for class work in the life sciences. In the event there were no volunteers for the

hospital, this part of the program would be held in abeyance and all would work at the fort. Interaction with patients in the hospital would be left to the wishes of the pupils; there should be no attempt to force this involvement. At the fort site, however, a few patients could provide useful assistance in the work and some could even serve as supervisors to the pupils in their exploration. Attendance by some interested patients at the actual class sessions might serve as a further bridge between patients and pupils. This bridge is important. Both the school and the hospital see interaction as valuable to the groups of which they are the custodians. The school especially is interested in fostering the concept of giving, rather than simply getting, as part of a meaningful educational experience.

Evaluation

The significance of such giving will provide one of the measures for evaluating the success or failure of this experiment in education. From the standpoint of the hospital, any interaction, any giving, no matter on what scale, will mean the experiment was a success. It is difficult or impossible to attach numbers to their expectations, and it seems unnecessary to do so. But what of the school? Pupil reaction to the project would seem the best way to evaluate it. The degree of interest and enthusiasm are qualitative tests that the school faculty should be able to apply. A quantitative test might be the number of pupils volunteering for work in the occupational therapy section. If it should remain impossible to enlist the basic group of ten, then the effort could be considered unsuccessful.

Another test of success might be found in the alcoholic ward. At present, there is a fairly high return rate of these persons to the hospital (approximately 85%), although many possess skills valuable on the outside. Indeed, many of the patients on the occupational therapy program are alcoholics. If interaction with the pupils could result in some reduction of the alcoholic return rate, then the experiment could definitely be considered successful. It would not be difficult to monitor the progress of those alcoholics who worked with the teenagers. It might be possible to "assign" to pupils patients with usable skills but a record of returns to Long Island. Presumably, if interaction with Guild School pupils proved of significant therapeutic value, then these patients would demonstrate below average rate of return to the hospital.

Another test which might be applied is the incidence of pupil involvement in other community projects. Presumably, if the hospital experience has any relevance to the pupil, the social concern engendered there will carry over into other efforts involving the South End community. This is an admittedly loose and hard to define standard. Community involvement might mean simply that the school as a whole was succeeding. But the Long Island Hospital experiment is of central importance to the school in raising pupil concern for social involvement. Thus it is not unreasonable to make such willing involvement one of the measures of the experiment's success.

The Likely Outcomes

There are four probable courses that the Long Island-Guild School experiment might take, and two to three years of school involvement will be necessary before the outcome is obvious. The first alternative, and the one I consider the most desirable, would allow both the hospital and the Guild School to continue on the northern end of the island, at least until such time as the hospital is provided with an adequate facility on the mainland. A prerequisite of this is the provision of sufficient open space for use by the patients, with a definition of sufficient to come from the patients and staff themselves. While on the island, the Guild School would continue to expand and would involve other schools in summer programs, or possibly even in after-hours, year-round efforts.

The remainder of the island south of the hospital should be set aside for general recreation. Previous discussion of various island themes in history has pointed up the traditional image of an island as a special place, a place for the unusual, a place for escape. Few such places exist in the metropolitan area, especially ones that are accessible to the lower-income persons living in the vicinity of the harbor. Long Island could be made available to such persons, who would benefit by the recreation potential there. Low intensity uses are to be preferred, both in the interests of providing contrast to the surrounding urban context and to avoid possible conflicts with the

residents of nearby Squantum. Such recreation would require, as a minimum, improvement of the beach on Quincy Bay and provision of parking facilities. Approximately 4400' of beach could be developed on the Quincy Bay shore, accommodating perhaps as many as 11,400 on a peak summer weekend day. In the area behind this beach, sufficient space exists to accommodate approximately 2100 cars, slightly less, at four persons per car, than would be necessary if the beach were fully used and everyone came by private auto.

In addition, other facilities might be provided for various types of participatory recreation. Materials could be made available for construction of experimental environments, perhaps with the assistance and participation of certain hospital residents or Guild School members. Craft workshops might also be made available, staffed by local artisans and open for public use as well as use by some hospital patients. The Institute of Contemporary Art in Boston has already indicated an interest in such a venture. More conventional recreation areas could be provided, as indicated in the attached diagram. (See Appendix A, #7.)

The hospital, primarily for the seclusion of its alcoholics, should be physically separated from the general public by a fence. The alcoholics should remain on the island unless it is demonstrated by the experiment that they cannot interact successfully with the school or with other island users.

This alternative says, essentially, that things will go as they are, only more so, with both the school and the hospital benefiting from their interaction. The public will benefit also through use of the southern portion of the island from which they are presently barred. The hospital will move eventually, but only when suitable space is available elsewhere. A slight variation on this alternative might occur if the alcoholics were to move from the island. The facilities they use could be immediately absorbed by aged, indigent persons in the city, an occurrence which would not significantly alter the basic goals of the experiment.

The other alternatives say essentially, 1) more school; 2) less school; or 3) less hospital and school. The first implies that other schools would be given use of the island, taking over that portion south of the hospital and converting the entire space to an educational area. This would foreclose use of the island to the public and might introduce pupils in such numbers as to be detrimental to the hospital. But the success or failure of the Guild School experiment will shed additional light on the desirability of making Long Island an educational island in its entirety.

Of course, the school experiment may fail for a variety of reasons, in which case it is doubtful if any other educational institutions would be interested in the space. The hospital itself may move, either through

the efforts of the city or because of island purchase by the federal government. If the hospital moves, the Guild School would lose a major reason for its interest in the island. In any case, it could be assumed that removal of the hospital by either the city or the federal government would imply conversion of the island to regional recreation, a development that would preclude island use by any school.

The case for the first alternative thus rests on the assumptions that the hospital will be there for some time, probably at least ten years, and that the introduction of a school will be of immediate benefit to both patients and students. The choice of the South End Guild School is perhaps less well founded. Essentially, it was there and its staff was interested. They are sufficiently interested, it might be noted, that its director, Mr. Ridgway Banks, intends to take pilot volunteer group to the hospital immediately even should he fail to obtain the requisite funding for creation of the entire school.

No other defense of this thesis can be offered. The experiment, if successful, will be of value to the patients of Long Island Hospital. It will also be of value to the South End Guild School pupils. It may do something to reverse the commonly held image of the aged poor and the image of Boston Harbor as the recipient of all the city's unwanted activities. If it can do either of these, or both, the experiment will certainly have succeeded beyond all my aspirations for it.

Conclusion

This thesis began with the enthusiastic assertion that on a clear day, from the northern tip of Long Island, one could see almost forever. The time spent on the island in research for the thesis has not dulled this feeling. But it has sharpened my sense of the loss that Long Island represents now: loss to others who have no awareness of its beauty, loss to its hospital patients who have no chance to see other faces or hear other voices, and the loss to metropolitan Boston residents for whom use of the entire harbor is all but foreclosed. That the situation need not be so is a firm conviction with me and was, in fact, the real motivation for this thesis. If nothing else, I hope to have succeeded in conveying something of what Long Island is and who its people are. I feel strongly that <u>they</u> must come first and any development proposal that omits consideration of them must necessarily be inadequate.

Like the other islands, Long offers a landscape accessible to the dense urban core surrounding the harbor. Its spatial location and its size contribute enormously to its significance. That it should be available to more metropolitan residents seems self-evident; that such use must be sensitively designed is critical. It is my hope that this thesis will have made some contribution to the future of Long Island. It is valuable turf with forgotten people; neither should be neglected any longer.

BIBLIOGRAPHY

FEDERAL WATER POLLUTION CONTROL ADMINISTRATION, Report on Pollution of the Navigable Waters of Boston Harbor, U.S. Department of the Interior, May, 1968.

GOFFMAN, ERVING, Asylums, Garden City, New York: Anchor Books, 1961.

HALL, E. T., The Hidden Dimension, New York: Doubleday and Company, 1964.

KAYE, CLIFFORD, "Erosion of a Sea Cliff," Economic Geology in Massachusetts, University of Massachusetts, 1962.

KENNEDY, EDWARD M., "A Treasury of Islands," Boston Magazine, May, 1969.

LOWENTHAL, DAVID, ed., Environmental Perception and Behavior, University of Chicago, 1967.

LYNCH, KEVIN, The Openness of Open Space, unpublished paper, 1963.

METROPOLITAN AREA PLANNING COUNCIL, Open Space and Recreation Program for Metropolitan Boston, The Boston Harbor, Vol. 2, 1967.

REPORT OF THE M.I.T. STUDY GROUP TO THE MASSACHUSETTS HARBOR ISLANDS COMMISSION, The Harbor Islands, April, 1969.

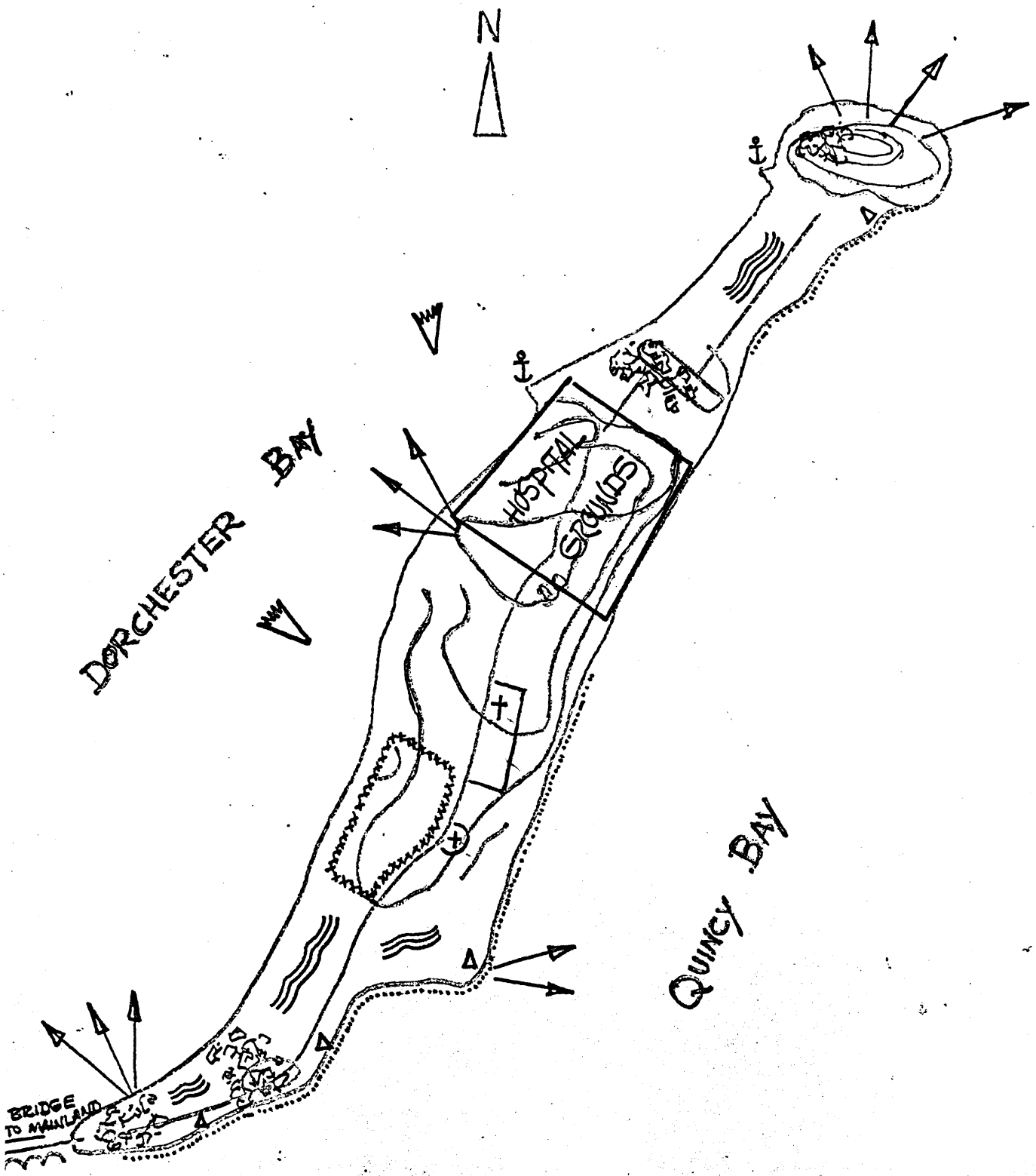
SIMPSON, R. W., Considerations Arising from Logan Airport, unpublished paper for the Boston Harbor Study Project, M.I.T. Department of Aeronautical Engineering, 1968.

Appendix A

GRAPHICS

1. Aerial photo of island. (Frontispiece.)
2. Site diagram.
3. Map of harbor showing island location.
4. Pollution map.
5. Results of test borings, Chapel, Long Island Hospital, John Guarino, Architect, 2 Lexington Street, East Boston, Massachusetts, June, 1958.
6. Site diagram of Fort area.
7. Plan for area south of hospital.


AERIAL
PHOTOS
of NEW
ENGLAND



TREES

BEST VIEWS

GROUND WATER

BEACH ACCESS Δ

SAND

FERRY LANDINGS

WINDS

CEMETERY †

NIKE SITE ××××

LONG ISLAND


EVERETT
CHELSEA
MYSTIC RIVER
BELLE ISLE MARSHES
ORIENT HEIGHTS
CHARLESTOWN
WINTHROP
EAST BOSTON
CHARLES RIVER
BOSTON
LOGAN INTERNATIONAL AIRPORT
BOSTON INNER HARBOR
DEER ISLAND
GREEN ISLAND
CALF ISLAND
CASTLE ISLAND
PRESIDENT ROADS
SOUTH BOSTON
PLEASURE BAY
BREWSTERS
CARSON BEACH
OLD HARBOR
DORCHESTER BAY
SPECTACLE ISLAND
GALLOPS ISLAND
LOVELL ISLAND
LONG ISLAND
GEORGES ISLAND
THOMPSON ISLAND
RAINSFORD ISLAND
NANTASKET ROADS
MOON HEAD
DORCHESTER
HOG ISLAND
PEDDOCKS ISLAND
HULL BAY
NANTASKET BEACH
SQUANTUM
HINGHAM BAY
QUINCY BAY
WOLLASTON BEACH
SHEEP ISLAND
BUMPKIN ISLAND
GRAPE ISLAND
WORLDS END
RACCOON ISLAND
SLATE ISLAND
WEYMOUTH FORE RIVER
HINGHAM HARBOR
QUINCY
WEYMOUTH
HINGHAM

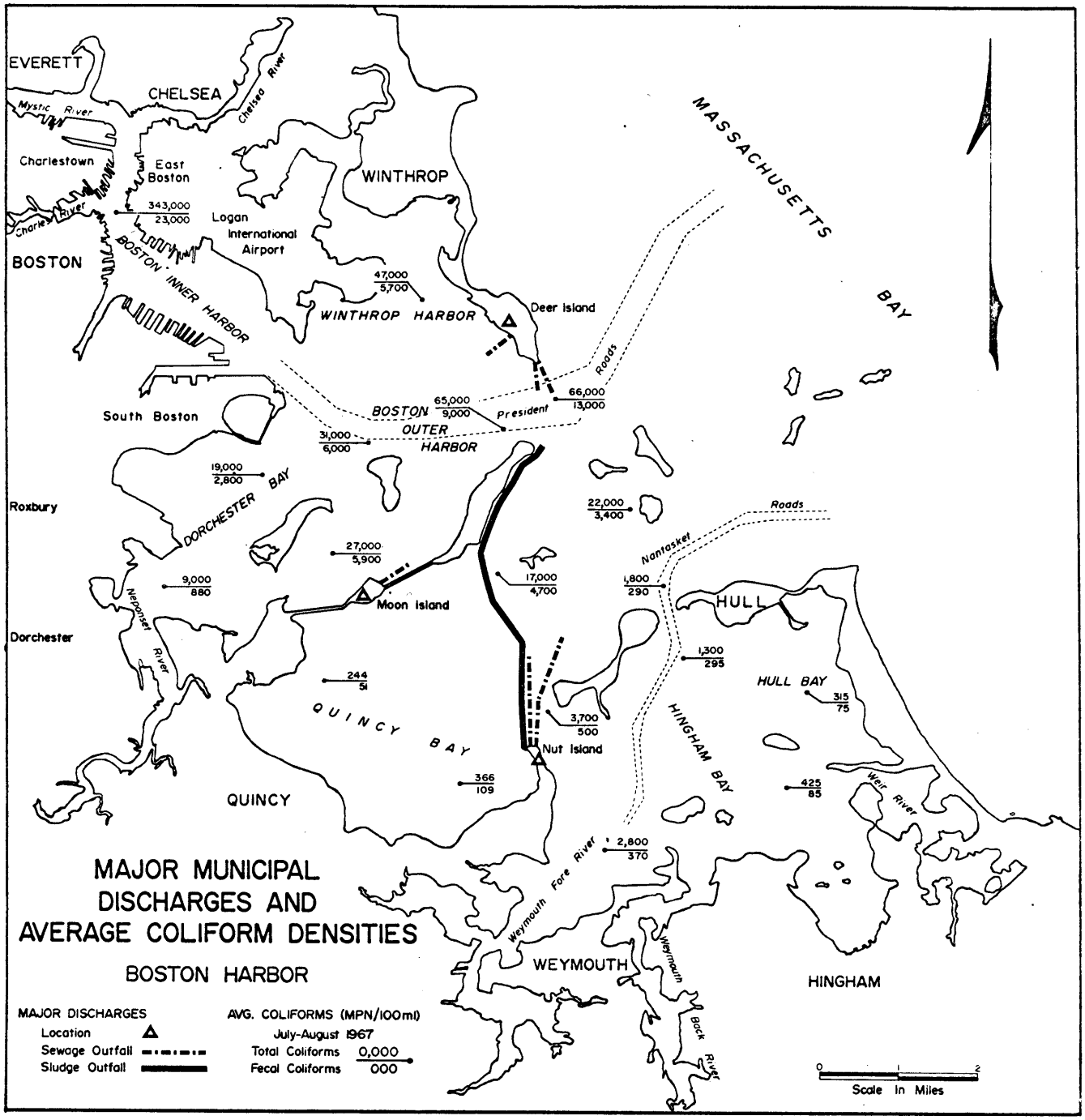

EVERETT
CHELSEA
Mystic River
Chelsea River
Charlestown
East Boston
Charles River
343,000
23,000
Logan International Airport
BOSTON
BOSTON INNER HARBOR
WINTHROP
47,000
5,700
WINTHROP HARBOR
Deer Island
MASSACHUSETTS BAY
Roads
66,000
13,000
BOSTON OUTER HARBOR
65,000
9,000
President
31,000
6,000
South Boston
19,000
2,800
DORCHESTER BAY
Roxbury
22,000
3,400
Roads
Nantasket
27,000
5,900
17,000
4,700
1,800
290
9,000
880
Moon Island
HULL
Neponset River
Dorchester
1,300
295
244
51
HULL BAY
315
75
QUINCY BAY
3,700
500
Nut Island
HINGHAM BAY
366
109
425
85
Weir River
QUINCY
2,800
370
Weymouth Fore River
WEYMOUTH
Weymouth Back River
HINGHAM
MAJOR MUNICIPAL DISCHARGES AND AVERAGE COLIFORM DENSITIES
BOSTON HARBOR
MAJOR DISCHARGES
Location
Sewage Outfall
Sludge Outfall
AVG. COLIFORMS (MPN/100ml)
July-August 1967
Total Coliforms 0,000
Fecal Coliforms 000
0
1
2
Scale In Miles

FIGURE 2

RESULTS OF TEST BORINGS

BORING #1
ELEV. 47.0

	LOOSE LOAM, SAND & GRAVEL	
4'	MEDIUM YELLOW SAND GRAVEL & CLAY	15
6'	COMPACT YELLOW SAND, GRAVEL, CLAY & BOULDERS	39
10'		

NO WATER ENC'D

BORING #3
ELEV. 51.0

	LOAM, SAND, GRAVEL & RED BRICK FILL	
6'6"	COMPACT SAND & GRAVEL	39
9'	COMPACT SAND, GRAVEL & BOULDERS	42
11'		

NO WATER ENC'D

BORING #4
ELEV. 54.5

	LOOSE LOAM, SAND & GRAVEL	
4'	MEDIUM YELLOW SAND & GRAVEL	15
6'	COMPACT SAND, GRAVEL, CLAY & BOULDERS	37
10'		

NO WATER ENC'D

BORING #2
ELEV. 45.5

	LOOSE LOAM, SAND & GRAVEL	
3'	MEDIUM YELLOW SAND & GRAVEL	18
6'-6	COMPACT YELLOW SAND, GRAVEL, CLAY & BOULDERS	42
10'		

NO WATER ENC'D

BORING #5
ELEV. 54.5

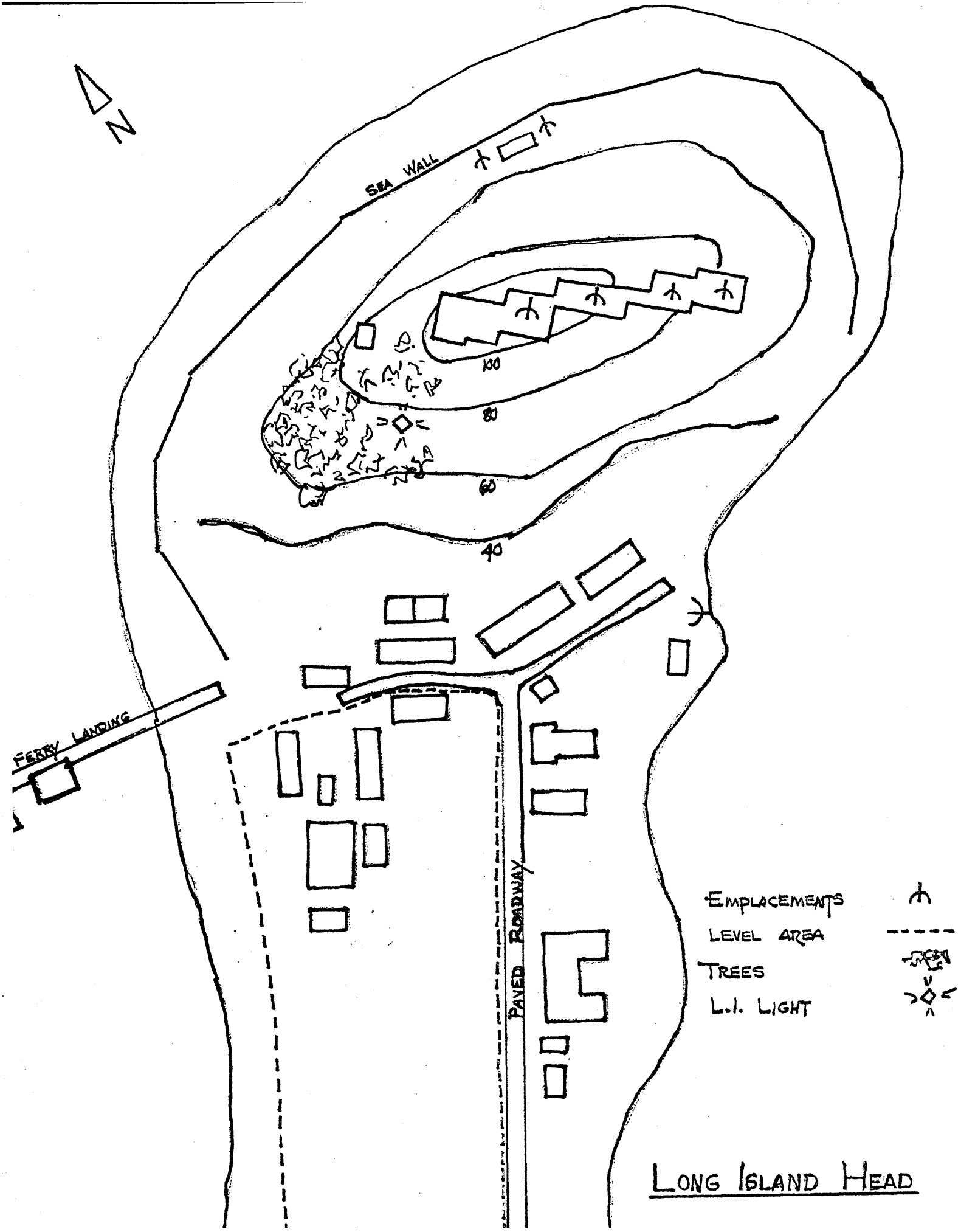
	LOOSE LOAM & SAND	2
5'	MEDIUM YELLOW SAND, GRAVEL & CLAY	13
7'-6"	COMPACT YELLOW SAND, GRAVEL, CLAY & BOULDERS	27
13'		

NO WATER ENC'D

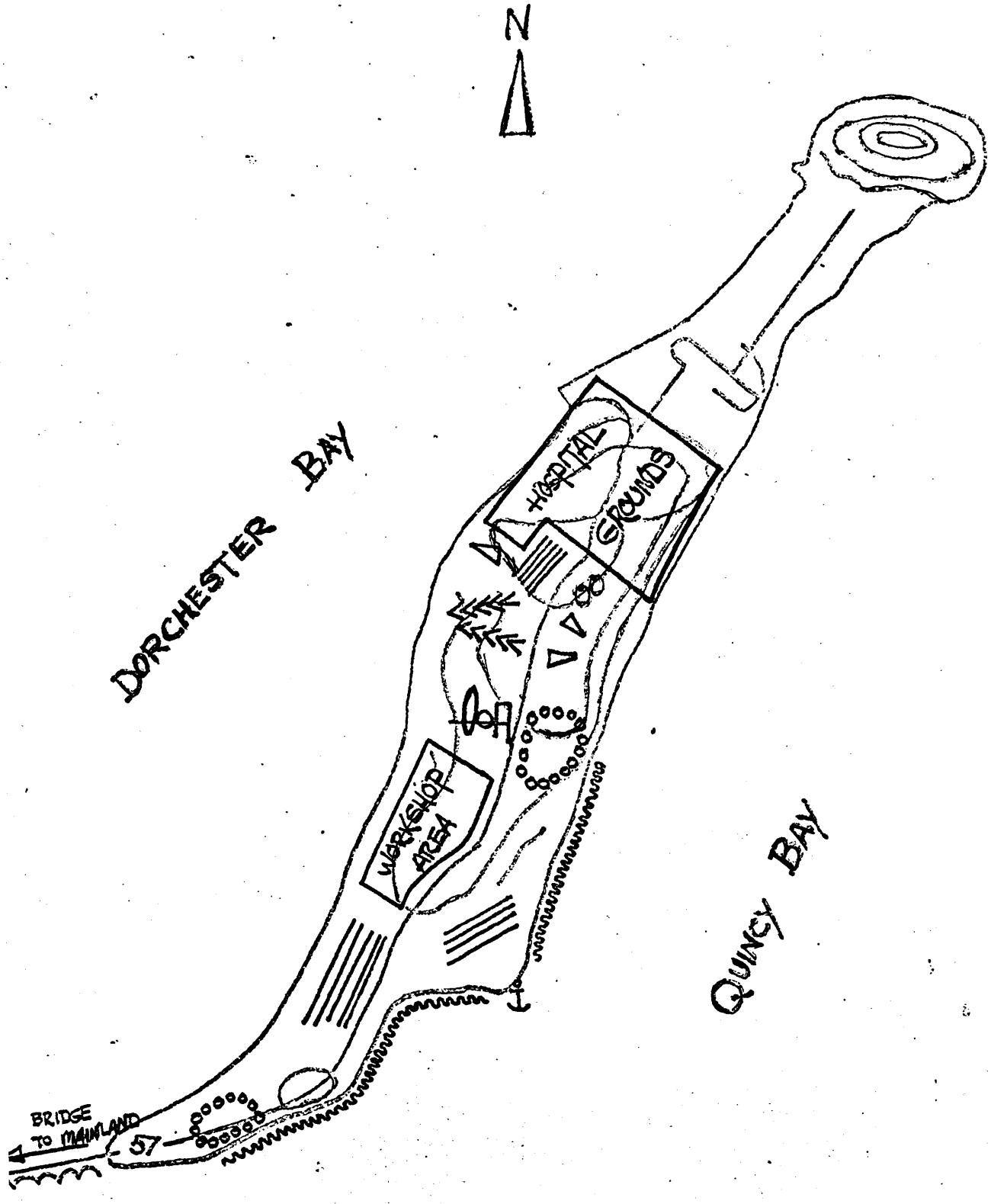
NOTE: ELEVATIONS ARE APPROXIMATE

FIGURES IN RIGHT HAND COLUMN INDICATE NUMBER OF BLOWS REQUIRED TO DRIVE 1 INCH SAMPLING PIPE 1 FOOT, USING 140 LB. WEIGHT FALLING 30 INCHES

TEST BORINGS TAKEN BY CARR CONSTRUCTION CORP. 11 BEACON ST. BOSTON MAY 20, 1958.



LONG ISLAND HEAD



BEACH

PARKING

FERRY LANDING

VIEW AREAS

SLEDDING SLOPES

LOW INTENSITY, PICNIC AREA

EXP. ENVIRONMENT AREA

LONG ISLAND

Appendix B

SKID ROW AND ALCOHOLISM

Residence on skid row and chronic alcoholism are not equivalent problems, although, in certain cases, they may admit of similar solutions. Distinctions between the row resident and the alcoholic are very often blurred, even at institutions, because alcoholism is the chief disease of the row (30%-40% of treatment load in clinics serving skid rows[1]) and the alcoholic derelict is its most visible resident. Bogue identifies eleven reasons for the existence of skid row, summarized below:[2]

1. cheap lodging and food;
2. employment opportunities for laborers;
3. tolerance for deviant persons;
4. rejection by family and local community;
5. withdrawal from society;
6. companionship and association with peers;
7. welfare activities of missions and other agencies;
8. opportunities for unlimited and cheap drinking;
9. secondary importance of physical appearance;
10. low standard of living;
11. tolerance of homosexuals.

It is clear that no single institutional approach can adequately address itself to all these reasons in a search for ways to eliminate skid row. Indeed, it is frequently stated that present treatment services available

at missions, outpatient clinics, etc., only serve to perpetuate skid row through ameliorating its symptoms.

In any case, the problem presented to the Long Island Hospital alcoholic ward is one of the derelict, the person who is both a resident of skid row and an alcoholic. The hospital is thus attempting to deal with a two-pronged problem, largely through traditional methods.

Nationally, there are three commonly used therapeutic approaches to alcoholism.[3] All three are employed in varying degrees at Long Island.

1. Group psychotherapy;
2. Lectures and discussions;
3. Alcoholics Anonymous meetings.

In addition, more recent practice involves the "therapeutic community," an attempt to make the patient's total daily experience part of the cure. Under this approach, patients must make their own decisions about work, clothing, etc. Most institutions, however, including Long Island, still rely on traditional procedures and maintain a more custodial atmosphere.

Experiments have been tried, of course, although apparently none of the sort presented in this thesis. In New York, Operation Bowery has proposed a detoxification center to be established at the Men's Shelter.[4] This center would provide doctors, nurses, social workers, and a psychiatrist to deal with the immediate physical needs of the derelict. In addition, an outpatient clinic will be set up where the alcoholic can return for group psychotherapy and guidance.

An experiment similar to this was also tried at Massachusetts General Hospital.[5] After passing through the detoxification center, men were assigned to teams consisting of a psychiatrist and a psychiatric social worker. They were invited to return to the center as often as necessary and assured that they would always see the same team. The experiment was successful in that 42% of the men returned to the clinic five or more times for consultations, as compared to the usual 1% return rate for emergency ward cases.

Although no one solution seems ideal for the problems of the skid row derelict, such persons present, nationwide, certain very similar characteristics. They are overwhelmingly male (96%) and white (90%). They are also poor and uneducated, with a median yearly income of approximately $1,000 and median education of eight years.[6] Their median age is 55 and is increasing. More than half are subsisting on some form of pension or welfare payment; more than half live in cubicle hotels where the price of a room 4½ feet by 7 feet ranges from about $0.50 to $1.25 per night. But apart from these bare statistics, these men share something else: they lack significant ties to other people. Plaut states that such social isolation is <u>the</u> problem of skid row.[7] It is this problem at which the Long Island experiment I have proposed is aimed. Little else is apparently being done to introduce alcoholic derelicts to different groups of people <u>during</u> their period of institu-

tionalization, yet it seems reasonably clear that innovative approaches are necessary. The problem of skid row is too significant and the reasons for the row's existence are too diverse to rely solely on traditional means.

Appendix B

FOOTNOTES

1. Peters, James B. Alternatives to Skid Row. M.C.P. Thesis, M.I.T., 1967.

2. Bogue, Donald J. Skid Row in American Cities. University of Chicago, 1963.

3. Plaut, Thomas A., ed. Alcohol Problems. Co-operative Commission on the Study of Alcoholism, Oxford University Press, New York, 1967.

4. Peters, op. cit., p. 47.

5. Plaut, op. cit., p. 81.

6. Peters, op. cit., p. 13.

7. Plaut, op. cit., p. 113.

Appendix C

LONG ISLAND HOSPITAL STAFF RESPONDENTS

John Gracey	Former Administrator
Donald Goldberg	Administrator
Muriel Burgin	Occupational Therapist
William Donnelly	Maintenance Director
Anthea MacAlister, M.D.	Physician
Anna Hickey, R.N.	Head Nurse
Jean McDonald	E.K.G. Specialist
Joseph Scally	Social Service Director